Pan-Birmingham NHS
Cancer Network

**Coversheet for Network Site Specific Group Agreed Documentation**

This sheet is to accompany all documentation agreed by Pan Birmingham Cancer Network Site Specific Groups. This will assist the Network Governance Committee to endorse the documentation and request implementation.

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| **Document Title** | Guidelines for the Assessment, Management and Referral of Patients Requiring Pelvic Exenterative Surgery for Gynaecological Cancers |
| **Document Date** | April 2010 |
| **Document Purpose** | This Guidance has been produced to support the following:<br>• Case selection criteria for pelvic exenterative services (PES)<br>• Detailed preoperative assessment and discussion of treatment options at the multidisciplinary meeting<br>• The preferred place of treatment for patients requiring Pelvic Exenterative surgery |
| **Authors** | Kavita Singh — Consultant Gynaecologist<br>Julie Winning — CNS Gynaecology Oncology<br>Lara Barnish — Deputy Director of Nursing |
| **References** | See document |
| **Consultation Process** | Gynaecology, Colorectal , Urology and Radiology NSSGs, Diana Webb, Clinical Psychologist and Robin Paijmans, Chair of Supportive & Palliative Care NSSG |
| **Review Date** (must be within three years) | April 2013 |
| **Approval Signatures:**<br><br>Network Site Specific Group Clinical Chair |  |
| **Date Approved by Network Governance Committee** | |

Pan-Birmingham NHS
Cancer Network

# Guidelines for the Assessment, Management and Referral of Patients Requiring Pelvic Exenterative Surgery for Gynaecological Cancers

**Version History**

| Version | Summary of change | Date Issued |
|---|---|---|
| Draft 0.1 | First Draft written by Julie Winning and Kavita Singh and circulated to the NSSGs for gynaecology, urology and colorectal | September 2006 |
| | Presented at the Gynaecology NSSG | September 2006 |
| Draft 0.2 | Following circulation to the NSSGs for urology and colorectal | September 2006 |
| Draft 0.3 | For circulation to the radiology NSSG following discussion at the NSSG 27.11.06 | November 2006 |
| Draft 0.4 | Following Radiology NSSG 17.1.07 and discussion with Peter Guest. | January 2007 |
| 1.0 | Endorsed by the Governance Committee | March 2007 |
| 1.1 | Prepared for review | February 2009 |
| 1.2 | Circulated to Gynae, Urology, Colorectal and Radiology NSSGs for review | April 2009 |
| 1.2 | Circulated to Gynae NSSG for final review and approval | May 2009 |
| 1.2 | Gynae NSSG approved | May 2009 |
| 1.3 | With Minor changes approved by Julie Winning and Kavita Singh | June 2009 |
| 1.4 | With comments from Karen Metcalf – circulated to JW, KS and Robin Paijmans | June 2009 |
| 1.5 | Following consultation with JW, KS and RP | June 2009 |
| 1.6 | Following consultation with JW, KS, RP and Diana Webb. For discussion at the NSSG Oct 2009 | July 2009 |
| 1.7 | Following NSSG for amendments by JW and KS | November 2009 |
| 1.8 | Version agreed by KS | March 2010 |
| 1.9 | With changes following review by Guidelines Review Group 6.4.10 | April 2010 |
| 2.0 | With minor changes from the review group ENDORSED. | April 2010 |

## Summary of changes made between version 1 and version 2

- *Greater clarity over case selection criteria (4.3)*
- *Role of Palliative Care (5g and 10)*
- *Pre-operative assessment to include dietetics and psychology*
- *Greater involvement of psychology services overall*

## 1. Scope of the Guideline

This Guidance has been produced to support the following:

- Case selection criteria for pelvic exenterative surgery (PES).
- Preoperative assessment and discussion of treatment options at the multidisciplinary meeting.
- The preferred place of treatment for patients requiring PES.

## 2. Guideline Background

2.1 PES for primary or recurrent gynaecological cancer is a modality of treatment undertaken for advanced gynaecological cancers confined to the pelvis. The treatment intent of PES can be either curative or palliative. Review of the literature reveals 3-year survival rates of 30% to 64.5% and 5-year survival rates of 9% to 61%.

2.2 PES is associated with a high morbidity (30-50%) and mortality (5-33%). It is usually offered when other modalities of treatments like radiotherapy and chemotherapy are no longer a suitable treatment option. Effective pre-operative assessment by expert teams working in cancer centres is paramount to ensure candidates are appropriately identified and outcomes are optimised. Informed consent and extensive counselling are essential elements of patient management, to ensure patients are fully aware of the potential risks and morbidity associated with this type of surgery.

2.3 PES can be:

a) **Total Pelvic Exenteration**
Where the bladder, uterus, tubes, ovaries, and anorectum are removed. This could be translevator when all the vagina is removed or supralevator when part of the vagina along with the pelvic diaphragm is preserved.

b) **Anterior Exenteration**
Where the bladder, urethra and gynaecological organs are cleared.

c) **Posterior Exenteration**
Where the anorectum along with the gynaecological organs are removed.

d) **Supralevator (modified) posterior exenteration**
Involves rectosigmoid resection along with en bloc removal of uterus, cervix, tubes and ovaries and is supralevator

e) **Infralevator posterior exenteration** (anovulvectomy)
This involves enbloc removal of vulva, anus and part of rectum. The excision is below the pelvic diaphragm

2.4 In Pan Birmingham Cancer Network PES is carried out by the PES team which forms part of the Specialist Gynaecological Oncology MDT (SMDT) at Sandwell and West Birmingham NHS Trust: City Hospital site. The pathway for this service is given in Appendix 1.

## Guideline Statements

### 3 All Patients

3.1 All patients to be considered for PES must be referred for a consultation with a gynaecological oncologist from the specialist multidisciplinary team.

3.2 All patients, irrespective of their source of referral, should undergo the following assessment: full clinical history and clinical examination, CT scanning of abdomen, pelvis and thorax, and a bone scan. If CT proves negative of metastatic disease, or equivocal, the patient should then be considered for PET scanning.

3.3 All patients to be considered for PES must be discussed at the SMDT.

### 4. Case Selection Criteria

4.1 Cases should be carefully selected after having excluded non-surgical options of treatment (chemotherapy/radiotherapy). Patients need to be well motivated and understand the surgical morbidity and consequences of the procedure on their quality of life.

4.2 In most cases this procedure is carried out with curative intent. In rare cases it may be deemed appropriate to carry out a PES as a palliative measure to control local disease in patients with a reasonable life expectancy.

4.3 The indications for PES include: -

*Cervical Cancer*

a) Recurrent disease confined to the pelvis, and not extending to the pelvic bones.
b) Persistent residual disease following chemo-radiation and/or Stage III or Stage IV with active or palliative intent.
c) Patients who are not able to have radical chemo-radiation because of previous radiotherapy for other conditions, or conditions that may lead to significant toxicity from radiotherapy.

*Endometrial Cancer*

a) Recurrent disease confined centrally to the vaginal vault.
b) Persistent residual disease following previous adjuvant pelvic radiotherapy.

*Vulval / Vaginal Cancer*

a) Primary or recurrent disease of the vulva or vagina involving adjacent pelvic organs.

*Ovarian Cancer*

a) PES is performed if recurrent disease is confined to the pelvis.

## 5. Specialist Multi Disciplinary Team for PES

After a patient has been selected for PES then she should be discussed formally with the specialist PES team who will be involved with the subsequent care. This will include the following:

a) Gynaecological surgeon
b) Colorectal surgeon
c) Urological surgeon
d) Clinical psychologist
e) Clinical nurse specialists in gynae-oncology, colorectal and urology, as well as for sexual rehabilitation support.
f) Dietetics / nutrition team
g) For patients whose treatment intent is palliative, the specialist palliative care team should also be involved in the MDT discussion.

## 6. Pre-operative Assessment

6.1 All patients should undergo the following assessment co-ordinated by the PES team.

a) Clinical assessment of the disease by gynaecological oncologist lead for PES.
b) Imaging of the disease including CT and / or PET scanning.
c) Urology/colorectal inter-disciplinary team referral and assessment.
d) Full anaesthetic assessment including liaison with intensive care anaesthetist regarding the immediate postoperative care.
e) Full discussion and decision-making by SMDT for gynaecological oncology
f) Clinical nurse specialist referrals and assessments for gynaecological / colorectal / urological needs.
g) Nutritional assessment.

6.2 In addition, all patients should be offered referral to a Clinical Psychologist, and informed of the sexual rehabilitation support services available (via Birmingham Women's Hospital).

## 7. Post-operative Assessment

Patients should be assessed for their individual need post-operatively and may require some, or all, of the following:

a) Initial post-operative stabilisation within ITU/HDU for the first 24 – 48 hours or as clinical demand dictates.
b) Transfer for post-operative care to Ward D27, City Hospital site, ensuring full SMDT involvement.
c) Early referral for post operative psychology assessment should be considered for all patients not already under the care of the clinical psychologist.
d) Post-operative complications will be managed by designated specialists within related sites.

## 8. Follow-up

8.1 Patients will be followed up by the gynaecological oncologist in charge of their PES management for a minimum of 5 years post-procedure.

8.2 Longer-term follow-up may be of value to determine predicted survivorship and associated long-term effects of PES.

8.3 Psychological and psycho-sexual issues should be assessed by the Specialist PES Team, with referral to the psychology services and sexual rehabilitation support service if required. Vaginal reconstruction may be considered in collaboration with the plastic surgery team, after a 2 year disease-free period has passed.

## 9. Patient Information and Counselling

9.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant SMDT. The patient should have a method of access to the SMDT at all times.

9.2 Assessment and support from a clinical psychologist will be formally offered to all patients as part of their preoperative care and assessment.

9.3 All patients should undergo a holistic needs assessment and onward referral as required.

## 10. Palliative Care

Palliative care services will be available to all patients as deemed appropriate by the SMDT. A core member of the specialist palliative care team should be involved in the SMDT discussions about patients for whom the preoperative treatment intent is palliative.

## 11. Clinical Trials

11.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

11.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@adf.bham.ac.uk .

11.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

## Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2011/12.

## Authors


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**Approval Date of Network Site Specific Group** Date: March 2010
**Date Approved by the Clinical Governance Committee** Date: April 2010

**Approval Signatures**
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Signature Date June 2010

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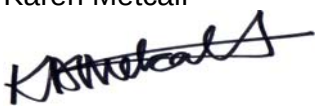

Signature

Date June 2010

**Network Site Specific Group Clinical Chair**
Name: Kavita Singh

Signature Date June 2010

## Appendix 1 Flow Chart of the Patient Pathway for Pelvic Exenterative Surgery